TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PAIN AND RECOVERY CLINIC

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-15-3257-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
JUNE 3, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were authorized."

Telephone Conversation with Anna Hernandez on July 22, 2015 verified that payment of $2,700.00 was received for December 19, 2014, December 22, 2014, December 23, 2014 and December 29, 2014. No payment had been received for December 5, 2014.

Amount in Dispute: $8,937.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It appears that Requestor has not spoken with the Claimant regarding reimbursement of these medical bills…Respondent contends reimbursement is not owed to Requestor due to Carrier's advance against future benefits."

Respondent's Supplemental Position Summary: "The amount of Respondent's holiday equals $3,891.54. Therefore, Respondent maintains its dispute of the dates of service 12/10/14, 12/11/14, 12/12/14, 12/15/14, 12/16/14, and 12/17/14 for a total amount of $3,750.00. The EOBs showing the amount to be paid has been sent to the Claimant; therefore, Requestor will need to contact the Claimant with regard to payment of those bills. Respondent has issued payment to Requestor for the dates of service 12/5/14, 12/19/14, 12/22/14, 12/23/14, and 12/29/14 for a total amount of $3,400.00. Attached are the payment screens. In conclusion, Respondent contends reimbursement is not owed to Requestor because Carrier's advance against future benefits for the dates of service 12/10/14, 12/11/14, 12/12/14, 12/15/14, 12/16/14, and 12/17/14."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 5, 2014 Through December 29, 2014	CPT Code 97799-CP Chronic Pain Management Program	$8,937.50	$700.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §417.002 outlines the process for recovery in third-party settlements.
3. 28 Texas Administrative Code §134.204 sets the reimbursement guidelines for the disputed service.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - 215-Based on subrogation of a third party settlement.
   - 247-A payment or denial has already been recommended for this service.
   - B5-Payment adjusted because coverage/program guidelines were not met or were exceeded.
   - B13-Preivously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. Is the requestor due additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code "215." The respondent states in the position summary "The amount of Respondent's holiday equals $3,891.54. Therefore, Respondent maintains its dispute of the dates of service 12/10/14, 12/11/14, 12/12/14, 12/15/14, 12/16/14, and 12/17/14 for a total amount of $3,750.00." Therefore, Texas Labor Code §417.002(a-c) applies to these dates.

   Texas Labor Code §417.002(a-c), RECOVERY IN THIRD-PARTY ACTION states,

   > The net amount recovered by a claimant in a third-party action shall be used to reimburse the insurance carrier for benefits, including medical benefits, that have been paid for the compensable injury. (b) Any amount recovered that exceeds the amount of the reimbursement required under Subsection (a) shall be treated as an advance against future benefits, including medical benefits, that the claimant is entitled to receive under this subtitle. (c) If the advance under Subsection (b) is adequate to cover all future benefits, the insurance carrier is not required to resume the payment of benefits. If the advance is insufficient, the insurance carrier shall resume the payment of benefits when the advance is exhausted.

   The Division reviewed the submitted documentation and finds:

   - No documentation was submitted to refute the explanation of benefits/carrier's position that the service in dispute are subject to payment from a third-party settlement; and
   - No documentation was found to support that the net amount recovered in the settlement was exhausted.

   The Division concludes that the requestor has failed to support that the disputed services rendered on 12/10/14, 12/11/14, 12/12/14, 12/15/14, 12/16/14, and 12/17/14 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

2. Based upon the submitted documentation the respondent did not maintain the denial of payment for the chronic pain management services rendered on 12/5/14, 12/19/14, 12/22/14, 12/23/14, and 12/29/14 based upon reason code "215". The respondent states "Respondent has issued payment to Requestor for the dates of service 12/5/14, 12/19/14, 12/22/14, 12/23/14, and 12/29/14 for a total amount of $3,400.00. Attached are the payment screens." The respondent submitted copies of payment screens that indicate a total of $3,400.00 has been paid: $2,700.00 for dates of service in dispute plus an additional $700.0 for a date that is not in dispute.

   On July 22, 2015, the Division contacted the requestor's representative, Anna Hernandez, who stated that payment of $2,700.00 had been received for dates of service December 19, 2014, December 22, 2014, December 23, 2014 and December 29, 2014, and no payment for December 5, 2014.

   28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

   (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

   (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   The Division finds that the requestor billed CPT code 97799-CP for 34 hours on December 5, 2014, December 19, 2014, December 22, 2014, December 23, 2014 and December 29, 2014. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is $100.00 per hour ($125.00 X 80%). $100.00 times the 34hours billed is $3400.00. The respondent paid $2700.00. The difference between the MAR and amount paid is $700.00. This amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $700.00. The Division emphasized that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. Even though all the evidence was not discussed, it was considered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $700.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/24/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.